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THE WITNESS: Okay.
BY MR. MANGI:
Q. So you understood that Bioscript was acquiring drugs for less than what you were paying them, but you didn't know what specifically they were paying; is that correct?
A. Correct.
Q. Now, from the physician's perspective, how was the Bioscript arrangement going to work?
A. The physicians were going to get the drug -- they would ask Bioscripts for approval of the medication. They would fill out a clinical information form to determine -- that Bioscripts would use to determine whether it was appropriate for the use of that medication, that the patient needed that medication appropriately. And then once an approval was made, the drug was delivered either to the physician or to the patient.
Q. Now, when was the Bioscript arrangement implemented?
A. I believe it was either May or September of 2004.

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Q. Prior to implementation of the Bioscript arrangement, how did HAP determine the amount that it reimbursed physicians for services incident to drug administration?
A. We had a fee schedule.
Q. Was that fee schedule tied to the amounts Medicare was reimbursing for the same services?
A. For the most part. We have a fee schedule for virtually everything in the physician office, and with a fee tied to that. It's similar to Medicare but we have made modifications over the years where -- dependent on market conditions.
So whereas Medicare may not pay very much for OB services because there's not a lot of Medicare OB in the Detroit area, we don't have enough obstetricians, and so we want to -- we would like to attract as many as possible, so we have raised the fees for obstetric care here in Michigan to try to attract and keep obstetricians. So we don't -- we mirror Medicare but we're not exactly the same as Medicare.
Q. In other words, your starting point is

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Medicare's reimbursement amount for services but you then have the ability to increase or apply multipliers to those numbers in situations where market conditions dictate it?
A. Correct.
Q. Does that apply also to services incident to drug administration?
A. Correct.
Q. Now, what are some of the market conditions that have led HAP to increase its payments for services incident to drug administration?
A. Specifically for these drugs that we have administered through Bioscripts --
Q. Well, let's talk first about the period prior to the implementation of the Bioscript arrangement --
A. Okay.
Q. -- but in relation to the same drugs.
A. Okay. The -- pretty much mimic Medicare.
Q. So prior to the implementation of the Bioscript arrangement, HAP did not vary from the

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amounts that Medicare reimbursed in relation to services incident to drug administration?
A. Correct.
Q. Now, when the Bioscript arrangement was implemented, were those fees paid for services incident to drug administration changed?
A. Not at first, but then we realized that if the physicians weren't making more money off the margin of the drug purchase, that the amount of money they were making to supply some of these drugs that were really needed by the patients, the amount of administrative fees they were giving was approximately $75. They were saying they couldn't cover those costs, so they would just send the patient over to the hospital to have the drug administered there.
The hospitals would charge us a lot to administer those drugs in the hospital setting. Our contracts with the hospitals were to pay percentage of charges for anything done on the outpatient side, whether it's a blood test, an x-ray, or an IV infusion.

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We had the potential to be paying thousands of dollars for administration of an IV that we would pay $75 for on the outpatient side.

So we made a decision, as did Medicare, that they needed to pay a little bit more for the outpatient administration so it would be attractive enough for the physicians to do it rather than spend the thousands that we would be exposed to be paying at the hospital.

Q. By outpatient, are you referring to physician offices?

A. Outpatient, physician offices, or hospitals have outpatient centers like infusion centers, ambulatory surgery, an emergency room was essentially an outpatient extension of the hospital.

Q. When you refer to the fact that it's cheaper for HAP if care is provided in the physician's office versus the hospital, were you comparing the physician office to the hospital inpatient setting?

A. Hospital outpatient setting.

Q. Okay. So HAP understood that if

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physicians were not able to treat patients in their offices, they would send them instead to hospital outpatient departments to get the same drugs?

A. Correct.

Q. And that would end up costing HAP more than if the care had been rendered in the physician's office?

A. Much more.

Q. Now, going back to your earlier answer, did I understand correctly that HAP recognized that historically the amount reimbursed for drugs had cross-subsidized the amount reimbursed for services?

A. Can you repeat the question?

Q. Sure. Well, after the Bioscript arrangement was implemented, HAP understood that the service reimbursements that were being paid to physicians were not enough to cover their costs, which would result in them sending patients to hospitals; right?

A. Correct.

Q. And historically those service fees had not been a problem because the physicians were

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making margin on the drugs that made up for any shortfall on the administration fee?

A. Correct.

Q. And HAP became familiar with this issue in 2003, 2004, after it implemented the specialty pharmacy arrangement?

A. Correct.

Q. Is this an issue that HAP had heard of prior to that time?

A. In my research of the subject, it was brought up as a potential concern, and realizing the way we did our contracts with hospitals, paying percentage of charges for outpatient care, saw it as a real problem that we would have to face.

Q. Was this research that you conducted prior to the implementation of the Bioscript arrangement?

A. Yes.

Q. Was it research you conducted in contemplation of the Bioscript arrangement?

A. Correct.

Q. What sources did you research?

A. The pharmacy literature. There were some

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editorials that were written in many of the medical journals regarding what -- what were the potential gains in terms of revenue for the healthcare system.

Q. Did these articles focus on the specific concern we have been talking about that margin on drugs had been used historically to offset, cross subsidize, inadequate reimbursement for services incident to drug administration?

A. I don't remember specifics. I do know that when a drug like Remicade was coming out that part of the selling point was that not only can a physician make some money off of administering the drug but, because it was an infusion, there was money to be made for the rheumatologist office in setting up essentially an infusion center. And there was the equivalent of an advice line for rheumatologists as to how to set up an infusion center.

Q. Now, when you elected to contract with Bioscript, was a notification sent out to physicians?

A. Yes.

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Q. Did you send out that notification?
A. It came from our Pharmacy Department.
Q. Was there any response from physicians to the implementation of this arrangement?
A. There was some complaint that they were going to be -- that they were going to be losing some money because we weren't going to reimburse them.
We actually had a satisfaction survey that was conducted of the physicians and it was remarkably positive in terms of they saw it as actually being quite helpful for the patients.
Q. Now, I believe you mentioned this arrangement was implemented in either May or the fall of 2004; is that correct?
A. Yeah, we had lots of implementations, so I can't remember which implementation it was.
Q. Okay. When you say lots of implementation, you're talking about lots of different programs or was Bioscript staggered?
A. Lots of different projects.
Q. Okay. Sometime in summer-ish of 2004?

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A. Correct.
Q. When was -- when were the fees paid for services incident to drug administration changed?
A. I'm not sure the specific date. Sometime within the last year.
Q. Okay. Sometime -- was it sometime in 2005?
A. I would guess so.
Q. What were the factors that led to that change?
MR. STEVENS: We discussed that.
THE WITNESS: Yeah.
MR. STEVENS: The hospital cost versus the --
BY MR. MANGI:
Q. We have discussed the general issue but I am asking what occurred to cause HAP to change its policy given that you had researched these issues prior to implementation?
A. Well, Medicare came out with their changes and so it was easy to adopt it.
Q. Did HAP receive any complaints from

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physicians after implementation of the Bioscript arrangement, raising the issue that we referenced of the admin fees being inadequate to cover the costs?
A. They did initially, but once the Medicare made their changes and we did also, then that helped.
Q. Okay. In the period prior to HAP changing its methodologies but after Bioscript had been implemented, did HAP monitor or see any trend in relation to physicians sending patients to hospitals as opposed to administering drugs in their offices?
A. Yes.
Q. And what was observed by HAP in that regard?
A. That certain physicians stopped sending the patients -- or stopped taking care of the patients themselves and sent them to the hospitals.
Q. Did HAP carry out any analysis as to what proportion of physicians the change had had that impact on?
A. No.
Q. Did HAP carry out any financial analysis

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as to the financial impact on HAP of having to pay for those drug administrations in hospitals versus physician offices?
A. We tried. It was just very difficult because the charges being sent in from the hospitals, they used many different code numbers, and it was difficult to compare apples to apples.
Q. Well, was this an isolated problem with a couple of doctors or was this a problem that was widespread?
A. I think it was widespread.
Q. When did HAP first realize this was occurring, patients were being sent to hospitals instead of receiving their physician-administered drugs in the physician office?
A. Oh, immediately upon implementation of the Bioscripts program.
Q. Who was in charge of dealing with that issue and considering possible solutions to it?
A. Me.
Q. And what steps did you take towards resolving that problem?

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A. Talked to many different individuals, both from the pharmaceutical industry as well as physician medical directors, billing experts, as to what type of changes we might be able to make, what were the possibilities to improve reimbursement just for those Bioscript drugs.

We pay for lots and lots of infusions and shots, you know, B-12 shots and IVs in an outpatient setting. The Bioscripts drugs were really a 1 percent portion of the type of infusions and injections we pay for.

So if we tripled the price of infusions for those 25 drugs, it will triple the price of the other 99 percent of B-12 shots and IV infusions across all of HAP. We actually calculated it. If we doubled the price, it would cost us an additional $2 million a year in infusions and --

Q. If you doubled the price -- I'm sorry, I didn't mean to interrupt.

A. Of all infusions and all injections.

Q. I see.

A. And so -- but it was against Medicare

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rules to increase the fee for injections and infusions just for certain drugs. Medicare I believe -- speculation on my part -- has realized that they recognized that there was an unfairness or a discrepancy in that and so they made the changes that they did to allow increased reimbursement for those biotech drugs.

Q. So what did you decide to do, then, in relation to actually dealing with this problem?

A. Well, since Medicare come up with a solution, we just adopted the Medicare solution.

Q. So when Medicare increased its reimbursement rates for services incident to drug administration after it had moved to ASP, you took the new service fees Medicare was using and implemented them for your own physicians who were using the Bioscript arrangement?

A. Correct.

Q. Did that resolve the problem?

A. It quieted the problem.

Q. Since that time, has Bioscript been receiving physician complaints in relation to the

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use of the Bioscript arrangement?

A. I haven't heard any complaints and I would be the one to get them.

Q. Now, let's turn to immunizations. You mentioned early in the day that HAP has recently increased its reimbursement for immunizations to 105 percent of Medicare.

Now, I understand correctly that immunizations are not supplied through the Bioscript arrangement; right?

A. Correct.

Q. Does 105 percent of Medicare apply just to the drug reimbursement or also the services incident to the administration?

A. I believe it was just for the drug.

Q. Are services incident to the immunization --

A. There's a fee schedule to give an immunization, or there's also a fee schedule to give an injection.

Q. And how are the amounts of those fee schedules determined?

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A. They are determined at the fee -- at the Fee Screen Committee or Provider Reimbursement Committee level.

Q. Do those amounts bear any relation to what Medicare reimburses in relation to the same services?

A. It should mirror them.

Q. Why was a decision made in relation to immunizations to pay 105 percent of Medicare versus Medicare itself?

MR. STEVENS: Asked and answered. He told you they did it because they wanted to encourage immunizations.

BY MR. MANGI:

Q. Now, is that correct?

A. That is correct.

Q. Okay. Now, when -- why did HAP decide that simply following Medicare and reimbursing at the same rate as Medicare would not result in sufficient utilization and access?

A. We wanted to go above and beyond Medicare because there was more money.

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Q. Did HAP evaluate whether simply following suit with Medicare would have an impact on utilization or accessibility?

A. One of the reasons to pay more money besides just trying to help the physician make more money by giving immunizations was that, number one, if they can make money giving immunizations, they'll do it themselves in their office and give better service to the patient so they won't be sending them off to, say, the local grocery store to get their flu shot or the Health Department to get their immunizations.

Secondly, if you compared the lists of immunizations comparing AWP to ASP, there's a general statement that ASP is lower than AWP but there are actually instances where ASP is higher than AWP for a particular immunization.

No matter how we changed the methodology or proposed methodology, physicians complained about they couldn't buy that immunization for that price, and so we were short-cutting them.

So I just wanted to make all the physicians

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happy. I didn't want to hear another complaint about how we were chintzing people on their immunizations, so let's just pay them as much as we possibly can so that everybody should be able to buy the drug and have their cost covered and make a little money on top of it when it comes to immunizations because it's the one thing that we can do almost universally to improve the health of our population.

MR. MANGI: Okay. This is a good time to take a break.

MR. STEVENS: All right. Take a half hour?

MR. WILLIAMS: How long do you want to break for?

MR. MANGI: You know, if you want to break for lunch now we can certainly do that. If you guys are so inclined, we can do another session. We're getting along faster than I expected. So if we do another session, then I'll have a sense of how far we have to go and maybe we can get done before lunch, if you want to have a late lunch, but

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whatever you prefer. We can break now.

MR. STEVENS: Well, if you think you're going to finish within an hour or so, hour and a half, something like that --

MR. MANGI: You know, why don't we do this. Why don't we take a five-minute break and then let's go to 12:30 and then we can either break for lunch or if we're looking closer, we can keep going.

MR. STEVENS: Okay.

(Recess at 11:51 a.m. to 12:02 p.m.)

MR. MANGI: Okay. Let's go back on.

BY MR. MANGI:

Q. Now, Doctor, before the break we were talking about the change that was made to reimbursement paid for services incident to drug administration after Bioscript was implemented.

Was the change to Medicare's new increased administration fees consistent and across the board or is there individualized negotiation?

A. It was consistent across the board.

Q. So since that change was made, there's

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been no negotiation with individual physicians or practices over the amount they will be reimbursed for services incident to drug administration?

A. There is not.

Q. Now, early in the day we were talking about your knowledge of what doctors pay to acquire drugs during the time you worked for various provider systems and health systems. Can you tell me now about any additional knowledge you have gained on that topic during your time at HAP?

A. Only that apparently doctors can buy things at different prices, based on complaints I hear from some physicians saying they can't buy it at a price we are reimbursing and asking for increases in reimbursement, but I don't know names of wholesalers or where they buy these things from.

Q. You mentioned earlier in the day that -- in relation to that question -- that you also were involved with formularies at HAP?

A. Correct.

Q. Have you learned anything about what's paid in the market to acquire drugs through your

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work in relation to formularies?
A. Not much.
Q. Okay. What is your role in relation to formularies?
A. I have been on the Pharmacy and Therapeutics Committee for HAP in the past. I am not right now. I have responsibility for our pharmacy use through HAP as far as how it fits into our overall budget, and my major concern really is that availability of appropriate medications for our practitioners.
Q. Does HAP have one formulary or is it a tiered formulary?
A. Tiered formulary.
Q. Does HAP's formulary cover only self-administered drugs, by which I mean drugs such as pills and patches, which a patient can use himself, or does the formulary also cover physician-administered drugs?
A. The formulary really is for outpatient medications.
Q. By outpatient medications, you're

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referring to self-administered drugs?
A. Things purchased at the drugstore.
Q. Do -- under the Bioscript arrangement, are physicians free to use any physician-administered drug they deem clinically appropriate or are there only certain drugs that can be used?
A. We have guidelines for the Bioscript drugs that we wish them to follow. So just as an example, Remicade can be used but it has to be used concomitantly with Methotrexate. And so if somebody wants to use Remicade but the patient isn't on Methotrexate, it will be denied. They have to try Methotrexate first and if they wish to use Remicade, they have to continue the use of Remicade because that's what has been shown in the studies will make Remicade most effective.
Q. Are there any drugs that -- leaving aside conditions and the circumstances in which the drugs can be used, like which you just described for Remicade, are there drugs that simply cannot be used, that are not covered?
A. We have what's known as an open formulary

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where if it's FDA approved that they can be used for certain medications. We require certain guidelines be followed in their use.
Q. So focusing specifically on physician-administered drugs, a doctor is free to use any drug that is approved by the FDA so long as he follows any guidelines that may be in place with that particular drug?
A. Correct.
Q. And Bioscript will handle any drug a physician may need as long as they follow those guidelines?
A. Bioscripts only covers the use of 24 or so medications.
Q. Now, what if a physician wants to use a physician-administered drug that is not on that list of 24?
A. They can do so.
Q. And how will they then be reimbursed in relation to that usage?
A. 95 percent of an AWP.
Q. So HAP continues to use 95 percent of AWP

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in relation to physician-administered drugs that are not covered by Bioscript?
A. Correct
Q. Do you have a sense as to how frequently such claims are submitted?
MR. STEVENS: In immunizations, as we've talked about?
THE WITNESS: Yeah, immunizations, but there are certain antibiotics. Ceftriaxone is an antibiotic used for treating certain childhood infections, as well as gonorrhea. Very commonly somebody comes in with gonorrhea, you give them a shot of Ceftriaxone. The physician sends us a claim for that and we pay 95 percent of AWP.
BY MR. MANGI:
Q. Okay. Let me ask you to exclude immunizations and antibiotics. Are there any other physician-administered drugs for which claims are submitted that you're aware of that are not part of the Bioscript arrangement?
A. Lots of different medications. Lasix is a water pill or injection, it's injectable form, used

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as a diuretic. So if somebody is in my office and they've got congestive heart failure in a severe form where I want them to get immediate treatment, we can give them either intramuscular or intravenous Lasix.

Q. Okay. Let me ask you a different question. Are you familiar with the fact that certain drugs are branded and certain drugs are generic?

A. Correct.

Q. Are you aware of the fact that there is a price difference between branded drugs and generic drugs?

A. Correct.

Q. Are you aware that the generic drugs are generally cheaper than branded drugs?

A. Correct.

Q. Now, in relation to physician-administered drugs specifically, what methodology has HAP used since 1990 to reimburse physicians for generic drugs that are physician administered?

A. 95 percent of AWP.

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Q. Now, when a physician bills HAP for a drug that's administered to a HAP member, the claim is submitted by reference to a J code; correct?

A. Correct.

Q. And J codes are not always drug specific; correct?

A. Correct.

Q. A J code may have different branded drugs within it, it may have a branded drug and generic competitors or it may have multiple generic drugs; right?

A. Correct.

Q. So would it be accurate to say that HAP reimburses at 95 percent of the AWP rate that's set for a particular J code as opposed to a particular drug?

A. Correct.

Q. Now, if one wanted to go to -- through HAP's claims data historically and figure out how much was paid for particular drugs specifically -- and I'm talking about particular NDCs of particular drugs -- would that be possible or impossible?

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MR. STEVENS: Object to foundation.

THE WITNESS: I would suspect we've got a database that at least goes back a few years but I'm not sure how far back it goes.

BY MR. MANGI:

Q. Well, is it possible to translate J code-based reimbursements to specific drugs NDCs?

MR. STEVENS: Foundation.

THE WITNESS: I don't know the capabilities of our information system on that.

BY MR. MANGI:

Q. Now, you mentioned earlier that one of your roles in your current position is analysis of the amounts that are being spent in different areas.

A. Correct.

Q. Is that correct? Is one of your roles analysis of the amounts that are being paid in relation to the usage of physician-administered drugs?

A. No. We look at pharmacy as a category, but we don't look at physician-administered drugs as a separate subset of that category.

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Q. Do you look at how much is being paid to Bioscript on any periodic basis?

A. We -- we have some data on what it is that they have supplied to our members and what the trends are with that.

Q. Okay. Does that analysis also look at how much HAP has been paying to Bioscript for drugs?

A. Yes.

Q. Is that on an annualized basis or some other periodic basis?

A. We get a report quarterly.

Q. Are you the person tasked with reviewing those reports?

A. Yes.

Q. What sort of issues are you assessing when you study those reports?

A. I'm looking at what are the trends in this particular case, what are the increases, and where are they occurring. I would like to know are we spending -- do we have more particular drug use in one part of the city versus another part of the city.

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Q. Okay. Now, if one were to suggest to you that HAP and you in particular don't pay much attention to what HAP is spending for physician-administered drugs, would that be accurate or inaccurate?

MR. STEVENS: I'm going to object to form, and it's argumentative.

THE WITNESS: We don't have separate detailed reports on what physicians are -- or any codes that physicians are asking for reimbursement for in their office.

BY MR. MANGI:

Q. Well, I understand that because you're using the Bioscript arrangement. My question is specifically in relation to that Bioscript arrangement.

A. Oh. Can you repeat the question?

Q. Sure. If one were to suggest to you that HAP does not pay any particular attention to the amounts it's paying Bioscript in relation to these physician-administered drugs that are reimbursed to its members, would that be accurate or inaccurate?

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MR. STEVENS: Same objection.

THE WITNESS: Inaccurate. We do pay attention.

BY MR. MANGI:

Q. Now, does HAP provide any Medigap products?

A. Do you mean Medicare complementary insurance?

Q. Supplemental insurance designed to cover Medicare beneficiaries' core charge obligations.

A. Yes, yes.

Q. Does HAP have one Medigap product or more than one?

A. I'm not sure.

Q. Since -- for how long has HAP provided a Medigap product?

A. I don't know. For eight years we have, and I'm not sure how long that goes back.

Q. How does HAP go about determining the premiums that it charges in relation to its Medigap products?

A. I'm sure -- I don't know exactly. I'm sure it's actuarially and/or community based.

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Q. Well, I'm not asking for specific accounting detail. At a level of generality, does HAP assess the amount that it's paying out in relation to reimbursements related to Medi-Gap insurance when determining how much it's going to set premiums at?

MR. STEVENS: Bruce, if you don't know, then don't answer.

THE WITNESS: Yeah, I don't know.

BY MR. MANGI:

Q. Okay. So you have no information as to how premiums are set in relation to Medigap products?

A. I have no idea.

Q. Now, are you familiar with price reporting compendia, such as Redbook, First Data Bank, or Medi-Span?

A. No.

Q. You have never heard of those publications?

A. No.

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Q. Now, this deposition is being conducted in connection with a litigation. Do you know anything about that litigation?

A. I have only heard a superficial summary.

Q. Now, leaving aside anything your counsel, Mr. Stevens, may have told you, do you know anything about this litigation?

A. Other than what he's told me, no.

Q. Okay. Now, I have some documents here, and you will be relieved to know we're not going to use all of them, but let me just ask you a few questions and then we'll mark them if necessary.

There are some documents produced by HAP that refer to physician extender policies. Are you familiar with that term?

A. In general, yes.

Q. Okay. What is a physician extender policy?

A. A physician extender is a non-doctor working in concert with a doctor to help take care of patients. So that would be, as an example, a physician's assistant or a nurse practitioner.

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Q. I see. And is a physician extender policy the policy that determines what's reimbursed in relation to that nurse or other assistant's services?
A. Yes.
MR. MANGI: Okay. Let's mark this particular document as Exhibit Niebylski 003 to the deposition.
(Exhibit Niebylski 003 was marked.)
BY MR. MANGI:
Q. Doctor, feel free to take your time and familiarize yourself with that document. I'm going to draw your attention to a particular part of it.
MR. WILLIAMS: Which document are we on?
MR. MANGI: This is HAPMI 007 to 8.
MR. WILLIAMS: The documents I -- oh, these were other documents that were produced?
MR. MANGI: Yeah, these were previously produced.
MR. WILLIAMS: Okay.
MR. STEVENS: It's a Fee Schedule Committee meeting minute, September 18th, 2003.

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MR. WILLIAMS: September 18th...?
MR. STEVENS: 2003.
MR. WILLIAMS: Okay. Thank you.
THE WITNESS: (Reviewing Exhibit Niebylski 003.)
MR. STEVENS: Just, if you're willing, it might be quicker if you would indicate at the outset what section you're interested in.
MR. MANGI: Yeah, absolutely.
BY MR. MANGI:
Q. We are going to at least start with the section on the second page marked, "Review of injectibles and infusibles." Are you ready to proceed, Doctor?
A. Yes.
Q. Now, earlier we talked about a Provider Reimbursement Committee. Is this a different committee?
A. No, this is -- the Provider Reimbursement Committee is the same as the Fee Schedule Committee.
Q. Okay.
A. Somewhere along the way we changed the

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name to sound different.
Q. Okay. Under "Review of injectibles and infusibles," first bullet point starts with HMS. Who is that referring to?
A. Health Management Services. That's my department.
Q. I see. Now, does this document and the date on it, September 18, '03, refresh your recollection at all as to when the Bioscript arrangement was implemented?
A. What did I say before, 2004?
Q. I believe you did.
A. Yeah, we're basing my knowledge of when we started Bioscripts on memory, and I just can't remember.
Q. Oh, sure.
A. It was sometime in the last couple years.
Q. Yeah. Well, my question is does what's listed here indicate to you that the Bioscript arrangement was already in effect as of September of 2003?
MR. STEVENS: (Indicating.)

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THE WITNESS: It looks like it probably was but I'm not -- I can't tell from this whether it was or not.
BY MR. MANGI:
Q. Okay. Now, the first bullet point there, that's referencing the same concern that we discussed earlier; correct?
A. Correct.
Q. And the second bullet point talks about increasing admin fees but whether one would be able to limit it to the Bioscript drugs, that's another issue we have already discussed; right?
A. Correct.
Q. Now, the third bullet point says, "The Group decides to drill down on Bioscript specific codes instead of all injectibles and infusibles." Is the group the Fee Schedule Committee or is that your HMS group?
A. The Fee Schedule Committee.
Q. Okay. Do you know whether the analysis that's contemplated here was performed?
A. We -- we have been analyzing, you know,

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Bioscripts' use since we started the Bioscripts program, and so does that answer your question?

Q. Well, let me ask it, then, by reference. Let me ask you another way by referencing the next bullet point. It says, "Group wants to review what is currently being paid for drugs to be provided through Bioscript for comparison to HMS proposal."

Now, was the HMS proposal that's referenced here shifting to Medicare's administration fees or was this something else considering the timeframe of this document?

A. The HMS proposal was my proposal, which was to increase what we were paying administration for Bioscript's drugs only. I'm just a doctor. I don't know how our computers work, but the group was saying that it was not possible to just select out the administrative fees for the Bioscript drugs and pay more for codes that we were also paying less for.

Q. Was your proposal to increase the fees for the Bioscript drugs services by any particular proportion?

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A. No. I just wanted -- I knew we needed to increase it.

Q. Okay. The next bullet point says, "Group wants to view industry comparison data on reimbursement rates for these drugs that will be obtained through Bioscript." Was that done?

A. We never got anything. We -- it's another way of saying what is everybody else doing, and Bioscript either didn't have or didn't want to give us that information.

Q. Were you asking what other health insurers were paying Bioscript or what other health insurers were doing generally?

A. What were other health plans doing, what were other Bioscripts customers doing in regards to the administration fees that were paid.

Q. I see. Okay.

MR. MANGI: Let's mark this as the next exhibit.

(Exhibit Niebylski 004 was marked.)

MR. STEVENS: This is a Fee Schedule Committee, August 18th, 2003, HAPMI 04 and 05.

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BY MR. MANGI:

Q. Now, Doctor, this is a meeting that took place about a month before the exhibit we just looked at. I'd like to draw your attention again to the discussion of the review of admin fees for injectibles and infusibles, the second page.

A. Yes.

Q. The first three bullet points reflect issues that we have already discussed. The third one specifically talks about the concern of physicians sending members to hospitals at a greater expense to HAP.

I'd like to draw your attention to the fourth point, "Group discusses the four admin codes that will need to be addressed." Where did these -- where did the focus on these four particular codes come from?

A. It's the -- it's a reference to the codes that were used for administering injectibles and infusibles.

Q. Okay. So at the time that you were contemplating changing only Bioscript drug-related

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service codes, you had focused on four particular codes?

A. Yes.

Q. Okay. And this is before it was determined that it would not be practical to only implement a change for Bioscript drugs?

A. Correct.

Q. Now, that bullet point continues, "Jody indicates that AMA has come up with global kit codes for the administration." Who is the Jody referenced there?

A. Jody is our Director of Benefit Administration. She keeps track of changes in reimbursement through Medicare, different things that are coming out from Medicaid, Medicare, AMA. And I think that was just something that she had read. She thought that the AMA had come out with a position on this.

Q. That's Jody Doherty?

A. Yeah.

Q. Do her responsibilities include analysis of any reports issued by the government pertaining

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to reimbursement?
A. No.
Q. Is there anyone at HAP who has responsibility for reviewing such reports?
A. Probably our compliance officer, maybe our finance people, but I'd be speculating.
Q. Okay. And what are the global kit codes that are referenced here?
A. I don't know. I think that she was trying to be helpful but I have never heard of that and haven't heard of it since.
MR. MANGI: Okay. Let's go off the record for a second.
(Recess at 12:31 p.m. to 12:46 p.m.)
BY MR. MANGI:
Q. Now, Doctor, do you know whether or not HAP receives rebates from drug manufacturers?
A. Yes, they do.
Q. Does HAP receive those rebates on all drugs or only on particular drugs?
A. Certain drugs that are contracted.
Q. By contracted, you're referring to

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contracts between manufacturers and HAP?
A. Correct.
Q. Are those contracts connected to formulary placement?
A. Usually.
Q. Does HAP receive rebates from drug manufacturers in relation to physician-administered drugs?
A. Not that I know of.
MR. MANGI: Let's mark as next deposition exhibit a document that bears Bates numbers HAPMI 56 to 183, which is a 128-page document.
(Exhibit Niebylski 005 was marked.)
BY MR. MANGI:
Q. Now, Doctor, I'm not going to ask you to look at every page, but you will see on the top right there is a page 1 of. Could you take a flip through this document and just familiarize yourself with it generally.
A. (Reviewing Exhibit Niebylski 005.) Okay.
Q. What is this document?
A. I believe it's a listing of rebates that

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HAP has received or at least a listing of the contracts that HAP has with the pharmaceutical manufacturers.
Q. Does HAP generate these reports on a periodic basis?
A. I'm sure it's updated annually.
Q. If I could just draw your attention to a particular page. You will see on the bottom of the page there are HAPMI numbers.
A. Yes.
Q. I'd like to draw your attention to page HAPMI 120.
A. Okay.
Q. And you will see at the bottom of that page there are rebates being paid in relation to Procrit. Continue on to the next page.
A. Okay. Okay.
Q. Now, are you familiar with Procrit?
A. Yes.
Q. You're aware that Procrit is a physician-administered drug?
A. Correct.

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Q. I'm trying to get an understanding as to what circumstances HAP receives rebates on physician-administered drugs such as Procrit, given that they are not subject to formulary placement. Do you have an understanding as to the circumstances under which that occurs?
A. No.
Q. Okay. So HAP does receive some rebates on some physician-administered drugs but you don't know what circumstances those rebates are paid in?
A. Contracts probably have lots of different criteria for payment.
Q. Okay. Let me show you another document. This bears Bates number HAPMI 21 and 22.
(Exhibit Niebylski 006 was marked.)
BY MR. MANGI:
Q. Now, Doctor, these are documents that were produced to us in sequence. Do you know whether these are part of the same communication or are these unrelated documents?
A. I -- I believe this was the same communication.

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Q. So looking at page HAPMI 21, is this a standard form letter that was sent to physicians informing them of the implementation of the Bioscript contract?
A. Yes.
Q. So when physicians were sent -- were notified of this, they were also given a list of the products that Bioscript would be supplying; is that correct?
A. Correct.
Q. And they were also informed of the rates at which HAP would be paying Bioscript for those drugs?
A. Yes. However, this is a larger list than what we have Bioscripts administering.
Q. I see.
A. I know our total list is about 24 or 25 different drugs. This is probably 70 or 80.
Q. Let me draw your attention to a specific aspect of these documents that may bear on whether or not they are, in fact, related. You will see the letter. The date on the letter, HAP 21, is

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September 1st, '03.
A. Yes.
Q. And if you have a look at the bottom right-hand corner of HAPMI 22, you will see there is a 2-7-05 date.
A. Okay.
Q. Does that indicate to you that these documents are unrelated to each other or is there some other explanation for that?
A. That would indicate that they're different.
Q. Okay. When the physicians were sent a notification of the Bioscript arrangement, do you have a recollection one way or another as to whether a list of drugs was provided to them?
A. It would make sense that it would have. I don't recall exactly what was on that list. I do know that Bioscripts had offered us to do more than the 24 drugs we selected but we did not want to actually do anything with the oncology drugs.
Q. When you say we did not want to do anything with the oncology drugs, what are you

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referring to?
A. We didn't want the oncology drugs to be included in the Bioscripts program.
Q. When Bioscripts was first implemented, were oncology drugs part of it?
A. No.
Q. Have they been a part of it at any point since?
A. No.
Q. So at the present time, is reimbursement for oncology drugs still at 95 percent of AWP?
A. Correct.
Q. And at the present time, how does HAP reimburse for services incident to the administration of oncology drugs?
A. Using the oncology administration codes that are in the fee schedule.
Q. Okay. Is that the Medicare fee schedule?
A. Yes.
Q. So HAP is using the current Medicare service fees incident to drug administration when reimbursing for oncology drugs?

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A. Correct.
Q. But HAP is not using Medicare's current drug reimbursement, which is ASP based; it's using 95 percent of AWP?
A. I'm not sure. I -- I really don't know. I am unclear on that.
Q. Which -- which aspect of it specifically are you unclear on?
A. I know Medicare had changed their reimbursement, and as I had said earlier, we decided to just reimburse at what Medicare was reimbursing. So given that logic, we are paying whatever Medicare is paying minus 5 percent.
Q. Okay. But you're not certain whether oncology reimbursement is AWP based or ASP based at this time?
A. Whatever Medicare is doing.
Q. Why did HAP want to exclude oncology drugs from the Bioscript arrangement?
A. There was a concern that there might be a public relations issue with changing reimbursement to oncologists for giving chemotherapy, and we knew

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that Medicare was looking at the problem. We decided that if there was going to be any changes, we would rather have Medicare take the heat rather than us. We didn't want to change anything. We didn't want to try anything new.

Q. What was the public relations issue that you are referencing?

A. There's a statistic in the industry that oncologists receive approximately 30 to 40 percent of their income from giving chemotherapy, and much of that is the margin that they are able to get from their purchase versus their administration of the drug and the reimbursement from the health plans. I didn't want to significantly impact the revenue being produced by oncologists since in my mind they perform a very valuable service. And by taking away a significant amount of revenue, I felt that that might cause a backlash in the community regarding what is HAP doing for cancer care for the people of southeast Michigan, and I didn't want to even go near there.

Q. Were you concerned that that may, that

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changing -- withdraw that.

Were you concerned that restricting that revenue to oncologists by putting oncology drugs in the Bioscript arrangement would lead to a problem with patient access?

A. Only indirectly. If oncologists said we don't like how you're paying so we're going to quit, yeah, it would impact access. I didn't fear that that was going to be the issue. My fear was that they were going to just create noise that would reflect negatively on Health Alliance Plan.

Q. How long had you been aware of the existence of the physician margin on oncology drugs that you referenced earlier?

A. Probably a few years.

Q. When the specialty pharmacy program was implemented in the 2003, 2004 timeframe, oncology drugs were left at the same rate that they had been reimbursed at previously; is that correct?

A. Yes.

Q. And has that rate been changed since?

A. I'm guessing now but my guess is we just

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followed whatever Medicare was doing.

Q. Have there been any PR issues that you are aware of in relation to oncology drugs specifically?

A. Nothing that's reflected on Health Alliance Plan.

Q. But in the '03, '04 period, when you were considering the implementation of the Bioscript arrangement, although you had been aware of the physician margin issue for some years, you made a purposeful decision to exclude it from the scope of the Bioscript program because of concern over public relation issues with oncologists?

A. Correct.

Q. Now, if you turn back to HAP 22, which is the document we were looking at, you will see that there are discounts listed on various drugs that range up to -- I see one that's 65 percent below AWP, which is towards the bottom right of the page. Do you see that?

A. Yes.

Q. Now, for the 24 drugs that are subject to HAP's contract with Bioscript, are they all at a

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flat AWP minus 15 rate or is there variation similar to what we are seeing in this chart?

A. There's variation, and I'm assuming that this is what we were paying Bioscripts at, 17 percent, 16 percent, 15 percent, what have you.

Q. Well, this document lists more drugs than are currently part of the Bioscript arrangement; correct?

A. Correct.

Q. Do you have a sense as to what the range of discounts of AWP is that HAP pays Bioscript?

A. I think this is our price listing, or it certainly looks like our price listing of what we paid Bioscripts. The question is which drugs did we use, and of the 80 or so drugs on this list, we had 24 or 25 of them that are on this list, and whatever we were -- whichever drugs we chose, the price that's listed here is the discount that we got.

Q. Now, oncology drugs have always been excluded from Bioscript; right?

A. Correct.

Q. What about hemophilia drugs?

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A. They were part of the program.
Q. So some of these hemophilia drugs have discounts of AWP, over here, the second one is 51 percent of AWP. Was -- did the discounts of AWP that HAP was paying to Bioscript range up to 51 percent of AWP?
A. Yes.
Q. Do you know what the greatest discount of AWP is on any particular drug that HAP gets from Bioscript?
A. It would be whatever is listed on this chart.
Q. For nononcology drugs?
A. Correct.
Q. Okay. So the discounts range from about 12 percent off on Refacto up to 51 percent of AWP on Alphanate; is that correct?
A. Correct.
Q. Let's turn to the next document.
MR. MANGI: If you will mark this as Exhibit Niebylski 007.
(Exhibit Niebylski 007 was marked.)

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BY MR. MANGI:
Q. This is a document Bates numbered HAPMI 9 to 10. And, Doctor, these are meeting minutes from it is now called the Provider Reimbursement Committee but this is the same as the Fee Schedule Committee we talked about earlier?
A. Yes.
Q. And this is from January 8 of '04?
A. Correct.
Q. Now, I'd like to turn your attention to the second page under the Heading code S 9430. Does reviewing the sub bullet points refresh your recollection as to the issue under discussion here?
A. Yes.
Q. Okay. Before we look at the document, what generally was the issue here?
A. The issue was still we wanted to improve the reimbursement in the physician office for administering Bioscript drugs. And in our research as to what could possibly be done to improve the fee without increasing the fee so that every B-12 shot and every Lasix shot would be reimbursed at a much

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higher rate, either another health plan or a consultant or whatever advised us that we could use this code S 9430 and allow physicians to not only bill their administrative fee for the injections and infusibles, but if they added this mixing fee that that would be a way of giving them extra money to encourage them to do it in the office instead of sending it to the hospital.
Q. Now, the second bullet point says, "HMS" - - that's your department; right?
A. Correct.
Q. -- "Proposes a fee of a hundred dollars." Was this a code that was already in existence or was this a new code that was being considered?
A. I don't know. I believe S codes are new codes, so they're temporary codes, so the reason they're temporary is because they're new.
Q. So it appears that HAP was considering putting into place a new code that would provide doctors who were getting drugs through the Bioscript program with an opportunity to bill for an additional mixing fee and thereby get additional

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revenue incident to the drug administration?
A. Correct.
Q. The next bullet point says, "Group discuss if code should be advertise" -- I guess that should be advertised -- "to the providers, HMS in favor of advertise to encourage providers to continue to perform in office."
Do you recall any further details of what was being discussed in relation to advertisement?
A. Well, the basic premise is that if you're going to pay someone extra to use this code, that the more you let them know that they can use it, the more they'll use it.
The counter argument is that if you start letting physicians know they can use this code, maybe people will use it for things like B-12 shots or for Lasix, what have you, and the concern was that they would just use it for everything because our software wasn't sophisticated to recognize that you should just use this for the Bioscripts drugs.
Q. And how did you weigh those issues?
A. Much discussion. I think we pulled the

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Solomon thing and just decided to cut the fee in half and advertise it to everybody.
Q. And how was the advertisement actually done?
A. Notice to providers who were prescribing Bioscripts drugs.
Q. Was that notice by letter?
A. Yes -- or, I believe so. I don't know for sure.
Q. Do you maintain a copy of that notice in your files?
A. No.
Q. Do you know if this code and the advertising relating to it is still in use?
MR. STEVENS: Foundation.
THE WITNESS: I don't know. I -- in talking to physicians, not a lot of them knew about this even after we had sent out notice.
BY MR. MANGI:
Q. Is this code still in use?
A. I don't know.
Q. Would you know whether the amounts set for

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reimbursement to this code was ever changed?
A. If it was, it was only in relation to overall changes, you know, 1 percent, 2 percent across the board kind of changes.
MR. MANGI: Let's mark the next document.
(Exhibit Niebylski 008 was marked.)
BY MR. MANGI:
Q. Doctor, this is a Provider Reimbursement Committee meeting minutes from January 29th of '04. I'd like to draw your attention to the bottom of the first page, the section under the heading Bioscript.
First bullet point is, "Laura: There is evidence that Beaumont physicians now send infusibles to the hospital and are not performing in-office since the implementation of Bioscript." Who is the Laura --
MR. STEVENS: Just a second.
(Discussion off the record.)
THE WITNESS: Laura is Laura Eory, E-o-r-y, who is one of our Directors of Contracting.
BY MR. MANGI:
Q. Now, what is the evidence that she was

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referring to here?
A. I believe that physicians had called asking for increases in the administration fees and, if not, we're going to send cases over to the hospital to be infused.
Q. The next bullet points refer to GRP. What is GRP?
A. Short for group.
Q. Oh, I see. And the group is the Provider Reimbursement Committee?
A. Correct.
Q. Next bullet says that the, "Group has requested a formal proposal from" you "of his administrative rate increase and to understand the parameters of this increase."
Is this still the increase that we referenced earlier that was a generalized increase, not pegged to Medicare, that was considered but not implemented?
A. My formal proposal was to -- was to increase the administrative rates and if possible selectively for those Bioscript drugs. I did not

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want to increase it across the board but I thought there's got to be somebody that knows how to do it just for those particular drugs.
Q. Okay. And the bullet that says, "Group decides to halt any analysis and consideration of increasing the admin codes." What is that referring to?
A. I think they wanted to see if, indeed, it was an issue that physicians were sending things off to the hospital instead of doing it in their office. The analysis of the Bioscripts program was to include how much is being sent off and what's happened to our change in administrative fees.
Q. So you wanted to wait to see the results of that analysis before deciding what to do?
A. Correct.
MR. MANGI: Okay. Next document.
(Exhibit Niebylski 009 was marked.)
BY MR. MANGI:
Q. Doctor, this exhibit is another set of Provider Reimbursement Committee minutes from August 3rd of '04. The second heading is, "MH/CD FS

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proposal." What is that referring to?
A. I don't know. I know the FS stands for fee screen or fee schedule. Mental health, chemical dependency.
Q. There appears to be some sort of a change in the fee schedule reimbursement being discussed here. Do you know what that is?
A. Not really.
Q. Okay.
A. I...best of my recollection, there was some modification in the way mental health was being paid for in terms of a lot of mental health is provided for group sessions, use of MSWs and Ph.D.s as well as psychiatrists, and so I think there was enough changes that there was concern that we needed to get new contracts for these people.
Q. Did this -- if you know, did this relate to service, psychiatric services or drugs administered by psychiatrists or both?
A. It wouldn't have had anything to do with the drugs. It would have to do with how we reimbursed the physician extenders.

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MR. MANGI: Okay. And this is the last one of these minutes. Mark this as the next exhibit.
(Exhibit Niebylski 010 was marked.)
BY MR. MANGI:
Q. Now, Doctor, this is a set of minutes from August 26, '04. You will see the second heading is Pathology, and then that continues over onto the next page. Are the bullets on the second page part of a discussion relating to pathology?
MR. STEVENS: There is a heading down at the bottom.
MR. MANGI: I see.
BY MR. MANGI:
Q. So the second page refers to RX administrative RVUs?
A. Yeah.
Q. Okay. Now, RVUs are resource value units; is that correct?
A. Yes.
Q. What is your understanding of what RVUs are or represent?

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A. I'm not an expert in RVUs other than it's a methodology used by different payers, Medicare included, to reflect physician effort and to set payments for procedures and office visits.
Q. Now, the second bullet here says -- well, the first is, "Group reviewed the impact of Medicare's increase in RVUs." So that's the increase that Medicare proposed in its administration fees when it was moving to ASP; is that correct?
A. Yeah.
Q. And then it says, "HAP should first back out increase impact to counteract Bioscript effect..." What does that mean?
A. I'm speculating now, but I believe the RVUs for administration and the different fee screen categories, like cardiology fee screens, urology fee screens, and then there was one for administration of drugs, and the RVUs for the administration of drugs sky-rocketed to reflect the increase that Medicare was going to be putting into that area. And so what that did, because there was a

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2,000 percent increase or something, the RVUs -- RVU changes were like a 2,000 percent change for those areas.
If you just calculated the effect changing our budget would do, the RVUs for the Bioscript -- for the administration of drugs would skew our overall budget. So it was a way of looking at what's the increases going to be for surgery and cardiology and radiology based on Medicare changes overall.
So let's just not look at the administration of these drugs, because we know there's going to be a big increase there, we want to see the effect it would have on our overall budget and not have the skewing effect that one category was going to put into the methodology.
Q. Now, this is the -- withdraw that.
Earlier we discussed the problem that when Bioscript was first implemented physicians started sending patients to hospitals, which was more expensive to HAP; right?
A. Correct.

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Q. And as we discussed, the solution that was eventually reached, after considering different alternatives, was to increase administration fees in line with Medicare's increase in administration fees?
A. Correct.
Q. Now, did HAP analyze whether in relation to these drugs that were part of the Bioscript arrangement, when it considered the Bioscript rate for the drugs plus the increased admin fees, it was paying more or less than it had for those same drugs and associated services before the Bioscript arrangement was implemented?
A. We did an analysis that we were saving money by having the Bioscripts program in effect.
Q. Despite the increase in admin fees?
A. Correct.
Q. Do you recall what the savings were?
A. It wasn't a very sophisticated analysis. If you just looked at the cost that we were paying compared to if we were paying what we were prior to what we were paying now, the cost was approximately

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a million and a half dollars per year.
It didn't -- the analysis did not do a very good job on the analysis of the administration cost because when the hospitals bill us, they used all sorts of different codes, so it was difficult to know whether some of those costs were actually for administration of drugs or they were post-op care or what have you.
Q. Well, you know, I think from the answer to my question it may have been a little unclear, so let me try and rephrase it.
I am not talking now about any hospital reimbursements, and I'm not talking about the impact of physicians sending patients to hospitals.
My question is focused on the physician office side of care. And my question is did HAP analyze whether the Bioscript drug amount plus increased service fee, the total it was paying now for those drugs and those associated services was more than it had paid to those same physician offices prior to implementation of Bioscript when reimbursement was 95 percent of AWP and there was a

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lower administration fee?
A. We knew there were savings.
Q. Is that something that HAP analyzed?
A. Yes. We know we weren't paying as much for the drugs, and the administrative fees were difficult to compare pre and post.
Q. Okay. Well, that's really -- that really is my exact question. Did HAP analyze or was able to figure out whether the increase in the service fees offset whatever savings you were making on the drugs?
A. That part of our analysis was not very clear. It was we weren't sure about the credibility of our data we were able to analyze, so I can't -- we do know we paid less for the same amounts of drug.
Q. Right.
A. And we don't know whether we were paying more or less for administrative fees.
Q. Well, I mean, you do know you were paying more since all the fees increased; right?
A. Right.

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Q. But you don't know how much?
A. I can't tell you the degree because it was -- because the claims were coming in from a variety of sources -- hospital, doctor's office, et cetera -- and different codes were being used for lots of different things. We could not sort it out to give a definitive answer.
Q. Okay. The next heading in the exhibit we are looking at is 2005 Fee Schedule Budget. Do you see that?
A. Okay.
Q. Second bullet there is, "Charlie suggested that the committee members adapt Medicare RVUs across the board using one conversion factor instead of separate groups as well as utilizing separate conversion factors for E&M codes." Who is the Charlie at issue there?
A. Charlie Carpenter.
Q. Okay.
A. He was the Director of Contracting.
Q. And what is the issue that Charlie was referencing here?

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A. Charlie wanted to keep our changes in our fee screen as simple as possible year to year. So he basically was saying let's just do whatever Medicare is doing every year, because we weren't doing that. We knew that there were certain market conditions that would require we pay OB/GYNS more, pay more for immunizations, what have you. So over the course of several years our fee schedule is different in some categories from Medicare based on market. Charlie was saying forget the market, let's just do exactly what Medicare is doing.

Q. And was his suggestion accepted?

A. No.

Q. And when he refers to a conversion factor, is he talking about using a multiplier to increase the amount over Medicare, although using their same basic methodology?

A. The conversion factor refers to as we go from one year to the next and we're going to increase our budget for payment to physicians of 1 percent or 2 percent or 3 percent, that conversion factor is that 1 or 2 or 3 percent.

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Q. What are the E&M codes referred to?

A. Those are the office visit codes.

Q. Are those services incident to drug administration or just general office visits?

A. General office visits.

Q. Why was Charlie suggesting separate conversion factors for the office visit fees?

A. I don't think he was. I think they miswrote in this. They didn't construct the sentence very well. What they meant to say was Charlie wanted everybody to just go on straight Medicare as opposed to the converse of what we have, which is separate conversion factors for different groups as well as for the E&M codes.

Q. All right. Now, do you review or are you familiar with HAP's contracts with providers?

A. I -- I know them in general.

Q. Are you aware that those contracts provide HAP with certain audit rights?

A. Yes.

Q. Okay. Does HAP inspect physicians' records pursuant to its contractual rights?

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A. Excuse me?

Q. Does HAP inspect physicians' records pursuant to its contractual rights?

A. In some cases we do so for quality reasons.

Q. As part of those audit processes, does HAP have access to information as to what physicians pay to acquire drugs?

A. No.

MR. MANGI: Let's mark the next document.

(Exhibit Niebylski 011 was marked.)

BY MR. MANGI:

Q. Could you familiarize yourself with that document and let me know when you are ready to proceed, Doctor.

A. Okay.

Q. Now, this letter is dated March 23rd, 2005. So this is after all of the changes that we have discussed have been implemented; correct?

A. Correct.

Q. And this refers to a period when -- well, withdraw that.

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This is -- this letter is from a physician to HAP; correct?

A. Correct.

Q. And it's regarding reimbursement for a venom extract?

A. Correct.

Q. Now, what sort of methodology -- is this one of the types of drugs that would fall within the other category that's being reimbursed at the same rates as Medicare?

A. It appears so.

Q. And the physician is complaining that the reimbursement does not cover what he is being charged for the product?

A. Correct.

Q. And it includes a price list showing the price he is being charged for the product?

A. Yes.

Q. Now, when physicians send in letters of this kind to the Provider Relations Department, do you see these or do these go entirely to a different department?

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A. They go to the Provider Reimbursement Committee for assessment as to whether to change the fee schedule or not.
Q. Are such letters received on a frequent basis?
A. We probably get 10 to 20 a year.
Q. What action is taken typically upon receipt of a letter like this?
A. It's presented at the Fee Schedule Committee and -- or Provider Reimbursement Committee, and we usually say, gee, you know, they're not covering their cost. Is this something we want to encourage or discourage, and if this is not good medicine or standard of care, we might deny it; if it's care that we think we really want to assure is provided to our membership, we usually change it.
Q. Do you know if it was done in this particular case?
A. I don't recall.
MR. STEVENS: I think there was another document attached to it that indicated they kept it

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at the same. This was the $43, is that what it was?
THE WITNESS: This is the $35 versus 13.78.
MR. STEVENS: Yeah. I'm sorry. I withdraw that.
MR. MANGI: Let's mark this as number 12.
(Exhibit Niebylski 012 was marked.)
BY MR. MANGI:
Q. Now, Doctor, I have a specific question about this document. You will see the date is July of '05.
A. Okay.
Q. It says, "Proposal. Follow current HAP policy and set fee equal to 100 percent of AWP."
Now, based on your testimony earlier, my understanding was that the rate used in 2005 was 95 percent of AWP for drugs that were not part of the Bioscript arrangement. Do you know what this 100 percent of AWP is referring to?
A. No, I don't.
MR. STEVENS: It's on the corner. Vaccines.

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THE WITNESS: Okay. What may be -- I know recently we went to 105 percent of AWP. We -- I believe we had a transition year in there where we were at 100 percent of AWP. Presently we're at 105 percent but I think somewhere in there we decided just to go at 100 percent, up from our 95 percent of AWP.
BY MR. MANGI:
Q. In relation to vaccinations?
A. Correct.
Q. Now, let's see if we can get this correct. When you testified earlier, you said that the rate for immunizations had been increased to 105 percent of Medicare over the last two years.
A. Yeah.
Q. But Medicare is not using AWP. So my question is is the rate for vaccinations now 105 percent of Medicare or is it 105 percent of AWP, because those are different numbers?
A. It's my belief that it's 105 percent of Medicare.
Q. So when this document refers to the

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current policy fee equal to 100 percent of AWP, you just don't know what that's referring to?
A. That was what it was prior to us changing it to 105 percent of Medicare.
Q. Well, prior to becoming 105 percent of Medicare, wasn't it at 95 percent of AWP?
A. I think we had a transition in there for a year, six months, two months, I don't know, but we -- this has been a three-year problem trying to stay ahead of complaints of physicians saying we're not getting paid enough to cover our cost of immunizations.
It's been at least a two-year discussion, if not three-year discussion, and we keep trying to change it. Medicare keeps changing. I'm sorry I can't give you exact dates of changes and what we did as a compensation.
I do know we used to be at 95 percent of AWP, which was consistent with Medicare, and now we're at 105 percent of Medicare. And whether Medicare using ASP or AWP or cost to Costco, I don't know. Whatever Medicare does, we're going to pay 5 percent

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more than them.
Q. Okay. That's fair. I understand you don't recall specific dates.
Am I correct, though, in understanding that the transition has been from 95 percent of AWP to 100 percent of AWP to 105 percent of Medicare?
A. Correct.
Q. Okay. Now, does the methodology that HAP uses to determine its reimbursement to physicians use a lower-of formula? In other words, is it the lower of a certain methodology or the provider's bill charge?
A. We pay a fee schedule.
Q. Okay. So in the cases of physician office reimbursement, is it fair to say that there's never reimbursement at the physician's bill charge?
A. I don't believe so. I don't know of any.
Q. I am just going to run through some of these documents and try and short-circuit them so we don't have to go through each one.
A. No problem.
MR. MANGI: Let's mark this one.

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(Exhibit Niebylski 013 was marked.)
BY MR. MANGI:
Q. Now, Doctor, would you take a look at that document, please, and let me know when you're ready to proceed.
A. Okay. (Reviewing Exhibit Niebylski 013.)
Q. Have you seen this document before?
A. No.
Q. Okay. When this refers to the CDC, do you have an understanding as to what the CDC is?
A. The Centers for Disease Control.
Q. So this document reflects that the CDC's cost for doses of particular vaccines is substantially less than private sector cost for those drugs; is that correct?
A. It appears so.
Q. Leaving aside this document, have you generally been aware of the fact that the government can purchase drugs at prices at substantial discounts?
A. I would think so. They're the most powerful country in the world, so....

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Q. Does HAP --
MR. STEVENS: At least the Canadian government can.
BY MR. MANGI:
Q. Does HAP systematically monitor the prices under which the government can purchase drugs, such as the CDC?
A. Not that I'm aware of, no.
Q. Do you have an understanding as to what context this document would be in HAP's files?
A. It might have been brought as a FYI. I have never seen it, so....
Q. Okay. And when you say you think so, it's because as a large buyer, you would expect the government to have leverage that would enable it to get good prices on drugs?
A. And even if they can't get leverage, they just make a law and say that's all they're going to pay.
(Discussion off the record.)
MR. MANGI: Let's mark these as the next two exhibits.

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(Exhibit Niebylski 014 and Exhibit Niebylski 015 were marked.)
BY MR. MANGI:
Q. Doctor, I have a quick question on these two documents that have been marked as Exhibit Niebylski 014 and Exhibit Niebylski 015.
Similar to the document we looked at earlier, are these other examples of physicians corresponding with HAP and including evidence of what they pay to purchase drugs, contending that they're not being reimbursed at a rate sufficient to cover their costs?
A. It's just documentation we get all the time like this, which is I can't buy it for any cheaper. Increase your price, please.
Q. So the answer to my question is yes?
A. Yes.
MR. MANGI: Okay. Why don't we take just a couple of minutes as a break. I think I am done. I just want to look through my notes.
MR. STEVENS: Wonderful.
(Recess at 1:41 p.m. to 1:48 p.m.)